ALABAMA MEDICAID AGENCY
MOTORIZED/POWER WHEELCHAIR ASSESSMENT FORM

Required attachment to the Alabama Prior Review and Authorization Form (Form 342). This form must be completed by an Alabama licensed physical therapist employed by an enrolled Medicaid Hospital through the hospital outpatient department.

PATIENT'S NAME: _____ _____
LAST NAME FIRST NAME

PATIENT'S MEDICAID #: _____ DATE OF BIRTH: _____

DIAGNOSIS: _____

HEIGHT: _____ WEIGHT: _____

DATE OF ASSESSMENT: _____

Note:
To qualify for a Motorized/Power Wheelchair, the patient must meet current manual wheelchair criteria and the Motorized/Power Wheelchair criteria under Medicaid.

Please submit this form as an attachment to the Alabama Prior Review and Authorization Form (Form 342).

I. POSTURAL CONTROL:

Head Control:	Good ☐	Fair ☐	Poor ☐	None ☐
Trunk Control:	Good ☐	Fair ☐	Poor ☐	None ☐
Upper Extremities:	Good ☐	Fair ☐	Poor ☐	None ☐
Lower Extremities:	Good ☐	Fair ☐	Poor ☐	None ☐

II. MEDICAL/SURGICAL HISTORY AND PLANS:

Describe orthopedic conditions and/or range of motion limitations requiring special consideration (i.e., contractures: degree of spinal curvature):

Describe other physical limitations or concerns (e.g., respiratory):

Describe any recent or expected changes in medical/physical/functional status:

III. FUNCTIONAL ASSESSMENT:

Ambulatory Status: Nonambulatory ☐ With assistance ☐

Short distances only ☐ Community ambulatory ☐

Indicate the patient's ambulation potential:

Expected within 6 mos ☐ 1 yr ☐ not expected ☐ expected in future within ___ years ☐

Wheelchair Mobility:

Is patient totally dependent upon wheelchair? Yes ☐ No ☐

If no, please explain:

Indicate the patient transfer capabilities:

maximum assistance ☐ moderate assistance ☐

minimum assistance ☐ independent ☐

Describe activities performed while in wheelchair:

IV. ENVIRONMENTAL ASSESSMENT:
(Home visit not necessary, physical therapist may obtain information from recipient)

Describe where patient resides:

Is the home accessible to the wheelchair? Yes ☐ No ☐

Are ramps available in the home setting? Yes ☐ No ☐

If no, will home be modified? Yes ☐ No ☐

V. REQUESTED EQUIPMENT:

Describe patient's current seating system, including the mobility base:

Describe why current seating system is not meeting patient's needs:

Describe the equipment requested:

Describe the medical necessity for mobility base requested:

Describe the medical necessity for the seating system requested :
(Justify any accessories such as power tilt or recline)

Describe the durability/adjustibility of equipment requested in number of years:
(How many years do we believe the equipment will be useful.)

Describe any anticipated modifications/changes to the equipment within the next three years:

Describe the medical necessity for power vs. manual wheelchair:

Is patient unable to operate a manual chair even when adapted? Yes ☐ No ☐

How will the power wheelchair be operated? (hand, chin, etc.)

Is the patient physically and mentally capable of independently operating the power wheelchair safely with respect to themselves and others? If no, explain.

Yes ☐ No ☐

Is the caregiver capable of caring for the power wheelchair and understanding how it operates?

Yes ☐ No ☐

How will training for the power equipment be accomplished?
a. Driving:

b. Caring for equipment:

Therapist's name: (print or type) Therapist's title:	Therapist's signature: Date:
Therapist's License #:	
Therapist's phone number: (_____) _____	
Therapist's employer: (Hospital)	Therapist's address: (Hospital address where assessment was done)

FORWARD TO: EDS, P. O. Box 244036, Montgomery, Alabama 36124-4036